Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Personal Training Intake Form

First Name: ________________________________ Last Name: ____

Date of Birth (MM/DD/YYYY): _____________________ Address: ____

City:_____________ Postal Code:______________ Phone: _____________________ Cell: __________________

Emergency Contact. ____

Email: ____ Occupation: ____________________________________

How did you hear of Visionary Health? ____

Please list your health concerns: ____

Are you currently being treated by any other physician(s) or healthcare practitioners?

What are your Fitness Goals?

____

HEALTH HISTORY:

Height: ______________ Current Weight: ______________ Approx. weight 1 year ago: _______________________

Blood type: A □ B □ AB□ O□

Allergies: (please list any know allergies including medications, environmental & food related)

____

Medications: (please list all prescription and non-prescription medications including birth control, aspirin, etc.)

____

____

Supplements: (please list vitamins, minerals or other natural supplements your are taking, with doses if known)

____

Accidents/injuries/hospitalizations/surgeries (date and type): ____

____

Experience:

Equipment (are you familiar with fitness tools)?: If so explain which ones:

Duration (time per session available) and Frequency (days per week available):

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INFORMED CONSENT FOR PERSONAL TRAINING

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

If you refuse any special procedure this will not affect you receiving other care or future treatments.

- I voluntarily request Mark Rajmoolie (CSEP-CPT) to examine and treat my health conditions. I understand that the course of care therapy may include the use of multiple modalities including: fitness/personal training methods, measurements, skinfolds, stretches, massage gun treatment, guidance for movements and positions of the body and muscles, weights, bands or resistance tools, scale and percent measurements.
- I understand that for the assessment/sessions, I will need to have certain areas visible (ie: waist, arms, legs) to take accurate measurements and skinfolds. If there is an area or measurement I do not wish to take, I am able to let the personal trainer know.
  I understand that there are some health risks with treatment from these therapies.
- These include, but are not limited to
  - Some minor pain, bruising and discomfort the day/week after treatment.
  - Aggravation of pre-existing symptoms and conditions from re-activation of the body's corrective healing capacities by energetic medicines
  - Sore muscles, limbs or extremities
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent form to treat for each and every special procedure at each treatment date.
- I understand that there is some minimal risk if I have any of the following: chronic fatigue, depression, insomnia, diabetes, damaged/sore skin, fragility of capillaries, oncological diseases, influenza, varicose veins, systematic diseases
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand that I have the right and the opportunity to ask questions about my condition, discuss options at any time.
- I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.
- I understand that payment is due in full at the time of service.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I agree to allow my medical records be shared with other medical professionals within Visionary Health only. Any other request of medical records must require a *medical release form* before releasing medical records to anyone other than the patient, unless so directed by myself or required by law.
- Payment of services, dispensary items, and other fees are due in full at each visit.
- A Missed Appointment Fee of $50 will be charged for any missed appointments or cancellations later than 9:30am of the business day prior to your appointment. (A business day is defined as Monday to Friday, excluding holidays)
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name (please print)

____

Patient Signature   Date

_______________________________________   ___________________________

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CONSENT TO TREATMENT OF SENSITIVE AREAS

TO THE PATIENT: During/after the initial assessment, your PT (Personal Trainer) may identify issues that could originate in the sensitive areas (chest wall, buttocks, waist, upper inner thighs/hips or breasts). The PT may need to further assess and devise a plan that includes one or more of these areas. As the patient, you have the right to be informed about your condition, recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withdraw your consent to treatment at any given point.

I,________________________(name), have requested assessment and/or treatment by PT, Mark Rajmoolie, for treatment of the clinically relevant areas indicated below (please initial the one applicable only):

_____ Buttocks (gluteal muscles)
_____ Chest Wall Muscles
_____Waist
_____ Upper Inner Thigh(s)/Hips
_____ Breast (s)

The PT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the skinfold methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
- The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at any time.

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Name (print): ____

Client Signature:____Date: ________________